State of Vermont **AGENCY OF HUMAN SERVICES**

DEPARTMENT OF MENTAL HEALTH
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DEPARTMENT of MENTAL HEALTH

Beneficiary Grievance and Appeal Procedures

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PART I

GENERAL GRIEVANCE AND APPEAL PRINCIPLES AND APPLICABILITY

A. INTRODUCTION

The State Medicaid Program, as a Managed Care Organization (MCO) under the Global Commitment to Health 1115 waiver, must have an internal grievance and appeal process for resolving service disagreements between beneficiaries and MCO employees, representatives of the MCO, and designated agencies. The overall goal of the grievance and appeal process is to resolve disputes fairly, to enhance beneficiary and public confidence in the equity and integrity of the service system, to ensure beneficiary access to clinically justified covered benefits, and to allow for the independent review of MCO staff decisions concerning appealable actions.

B. GENERAL PRINCIPALS

It is the goal of the Agency of Human Services to have a common Grievance and Appeal Process for all individuals served by Medicaid financed programs or services. The grievance and appeal procedures are intended to be:

- clearly communicated and consistently applied by all MCO components, programs, designated agencies and representatives;
- easily accessible, with assistance available as needed;
- confidential;
- free of retribution;
- adequately documented; and
- resolved within specified timeframes.

The procedures include a level of review by those not involved in the decision grieved or appealed. Resolutions of appeals will be clearly communicated to the beneficiary and his/her representative.

The OVHA will have a MCO Grievance and Appeals Coordinator who will be responsible for assisting the departments and agencies that are part of the MCO in the development and operation of their grievance and appeal procedures, monitoring the timely processing and resolution of all MCO grievances and appeals, and answering AHS and DA staff questions concerning these procedures.

C. APPLICABILITY

A. The procedures described in this document apply to the following beneficiary groups:

- Medicaid/Dr. Dynasaur
- Pharmacy programs
- VHAP

- Children financed through the State Child Health Insurance Program (SCHIP - is not part of the Global Commitment waiver)

B. Beneficiary Choice

Beneficiaries may choose to ask for both an appeal and a Fair Hearing at the same time, just an appeal, or just a Fair Hearing. They may also ask for an appeal while a Fair Hearing is pending. These procedures apply in those cases where an appeal or an appeal and Fair Hearing are requested. Beneficiaries are not required to complete the MCO internal appeal process before requesting a Fair Hearing.

If a request for a Fair Hearing has not been made prior to a MCO appeal decision, the Fair Hearing request must be made within 30 days of the decision.

Beneficiaries may call the Office of Health Care Ombudsman at 1-800-917-7787 for help with any part of this process or for help in deciding what to do.

PART II

MCO ADMINISTRATIVE FUNCTIONS AND RESPONSIBILITIES

A. STAFF SUPPORT - MCO GRIEVANCE AND APPEALS COORDINATOR

The OVHA will designate an individual as the MCO Grievance and Appeals Coordinator. This person will have responsibility for:

- Assisting the departments and agencies that are part of the MCO in the development and operation of their grievance and appeal procedures
- Maintaining data on MCO appeals and grievances
- Receiving grievances information summaries from each part of the MCO
- Analyzing appeal and grievances trends
- Identifying areas where standards are not being met
- Recommending corrective action when required standards are not being met
- Maintaining appeal and grievance procedures
- Responding to MCO staff questions concerning these procedures
- Periodically providing training to MCO staff when needed
- MCO grievance and appeal reporting to MCO entities and AHS

B. REVIEWERS

a. Appeals will be heard by the designated individual(s) from the department or agency responsible for the services that are the subject of the appeal.

b. Individuals hearing appeals will be appointed by OVHA Director or the appropriate official in each department (Commissioner or program director as determined by the respective department). One or more individuals will be appointed from each department or program entity that is part of the MCO.

c. If necessary, reviewers will be made available for specialized cases where additional clinical expertise is required.

C. DOCUMENTATION AND REPORTING

1. Data Documentation

a) Data Submission - Information on all MCO appeal decisions made by designated individuals shall be entered into the grievance and appeal database. The MCO Grievance and Appeals Coordinator will maintain the database.

b) Grievance and Appeal Data - All grievances and appeals will be documented in the grievance and appeal database, as will Fair Hearing requests and outcomes. The grievance and appeal database includes the following information:

All Cases Data Fields:

- Source (Beneficiary, Beneficiary Rep or Provider {appeals only})
- AHS Office Responsible (DAIL, DCF, OVHA, VDH, DMH)
- Specific Program (for DMH and DAIL use)
- Specific Entity (DA/SSA/program/vendor/individual)
- G and A Coordinator
- Date Received
- Due Date [automatically calculated]
- Date Information Input [automatically calculated] {backend}
- Beneficiary Information (last name, first name, SSN, DOB, Gender, Phone #, extension, Alternate phone #, Alt. extension, address, city, state, zip, Medicaid Category)
- Appealing Entity:
  - Representative Information (last name, first name, Phone #, extension, Alternate phone #, Alt. extension, address, city, state, zip)
  - Provider Information (last name, first name, Phone #, extension, Alternate phone #, Alt. extension, address, city, state, zip)
- Document and Letter "Storage" able to upload copies of letters
- Notes field

For Grievances:

- "Pertinent Issue" being grieved
- Date of pertinent issue
- Grievance Reviewer
- Category of grievance
- Outcome/Results
- Notification Letters (date due [Auto-filled] and date done)
- Grievance Review Requested
- Date Requested
- Notification Letters (same as above)

For Appeals:

- "Action" being appealed
- Service Category of Appeal
- Date of 'Notice of Action'
- Person Resolving
- Type of action appealed [based on rule language]
- Expedited (check box)
- Extended requested by (Beneficiary or MCO)
- Extended (check box)
- Resolution (Approved, Denied, Withdrawn – Orally, Withdrawn – Written, Partial Approval, Pending)
- Resolved Date
- Resolution/Decision
- Notification Letters (date due [Auto-filled] and date done)
- Check box if Fair Hearing is requested and date
- Fair Hearing outcome {drop down}

2. Reporting

a) Grievance Information Summary - The MCO Grievance and Appeals Coordinator in OVHA will regularly produce standardized reports on Grievance and Appeal activity for MCO entities and AHS based on elements included in the database. The Coordinator will also produce specialized reports requested by MCO entities, AHS, or other appropriate individuals or entities. The MCO Grievance and Appeals Coordinator will review the data and information submitted to identify any trends that may require further investigation and/or corrective action, and to ensure that grievances and appeals are being resolved in a timely manner.

b) The MCO Grievance and Appeals Coordinator will compile reports quarterly. Reports will be submitted to OVHA Director, AHS Secretary, and Commissioners of reporting agencies.

3. Other Documentation

All related correspondence and other pertinent documentation must be maintained in individual beneficiary files in the OVHA, contracted department or DA/SSA files and be retrievable for audits and reviews by the MCO or other authorized entity.

4. Beneficiary Notices:

Beneficiaries must be mailed a notice of action on or before eleven (11) days before the effective or start date of the proposed reduction or termination in service.

Generally notices must explain the action the MCO has taken or intends to take, the reasons for the action, the beneficiary's right to file an appeal, circumstances under which an expedited resolution is available and how to request one, and the beneficiary's right to request a Fair Hearing. Each part of the MCO must have and use a notice that meets legal requirements for Medicaid notices.

D. QUALITY IMPROVEMENT

As part of the quality improvement process, the MCO will review the grievance and appeal reports to ensure that the OVHA, contracted departments and DAs/SSAs are resolving beneficiary issues in a timely fashion and to identify any developing trends that may require further investigation.

MCO entities will submit grievance and appeal reports on a quarterly basis or other frequency as determined by AHS. These reports will identify grievance and appeal trends, corrective actions that have been taken by the entity, problems identified in the process, recommendations or suggestions for improvement, ways the entity has found to help the process which should shared with other parts of the MCO, and any other information requested by AHS. Reports will be submitted to the MCO Grievance and Appeal Coordinator.

PART III

DEPARTMENT AND PROGRAM POLICIES AND PROCEDURES

Procedures of the Department of Mental Health are in two sections. The first covers procedures for Designated Agencies and Specialized Service Agencies. The second covers the Department's policies and procedures.

SECTION I

DESIGNATED AGENCY OR SPECIALIZED SERVICE AGENCY APPEAL AND GRIEVANCE PROCEDURES

A. DA OR SSA APPEALS

1. Notices - original notice of decision

The DA or SSA Grievance and Appeal Coordinator will have responsibility for issuing or ensuring that beneficiary Notice letters are issued in all cases where Notice is required. Letters shall be in the format and with content approved by the Department and MCO (OVHA). A notice is required when the DA or SSA takes an 'action" that is subject to appeal. These include an occurrence of one or more of the following by the DA or SSA:

a. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;

b. reduction, suspension or termination of a previously authorized covered service or a service plan;

c. denial, in whole or in part, of payment for a covered service;

d. failure to provide a clinically indicated, covered service (no Notice letter);

e. failure to act in a timely manner when required by state rule (no Notice letter); or

f. denial of a beneficiary's request to obtain covered services outside the network.

Note: "Network" means the providers who are enrolled in the Vermont Medicaid program and who provide services on an ongoing basis to beneficiaries. DAs or SSAs would not be authorizing or denying services outside their own agency, so (f.) would not apply unless there is a change in the authority delegated to the DA or SSA from DMH.

2. Beneficiary Appeals

Beneficiaries have 90 days from the date on the decision letter to request an appeal. The DMH is responsible for hearing and deciding appeals. The DMH has 45 days to decide the appeal, with a possible 14-day extension (requested either by beneficiary or DMH).

The DA or SSA is responsible for specific administrative functions as identified in these procedures and for reviewing and reconsidering decisions made by their agency that are the subject of the appeal.

3. Examples of Decisions Requiring Notice

a. A DA/SSA determination of ineligibility for a DA/SSA managed program and /or a proposed change in the services detailed in a beneficiary service plan are both examples of actions that may be appealed. For example, a case manager may want to decrease the range of specific services described in the current individualized treatment plan in response to a beneficiary's improvements in that area of treatment, but the beneficiary does not agree with the change in range identified in the treatment plan. This kind of action, a plan change, requires a Notice to the beneficiary.

b. A beneficiary may request a new covered service from a contracted department or agency treatment team. However such a request may be denied when the treatment team does not believe such a service is indicated in the beneficiary's current treatment plan based on the beneficiary's condition or diagnosis or in light of best practice guidelines. In such instances, the beneficiary should be issued a Notice of the decision not to offer the service and provided with information about how to appeal that decision.

c. For any DMH program or a DA/SSA, any plan to deny a requested service or to authorize a service in an amount, scope or duration less than that clinically prescribed in the existing service plan require that the beneficiary receive a Notice

4. Reconsideration (optional).

Reconsideration of a service decision is optional process within the context of the MCO Grievance and Appeal rule. A beneficiary may decide not to ask the DA/SSA to reconsider a decision and go directly to the Department's appeal process or a Fair Hearing, or both.

However, if the reconsideration request is made or if a beneficiary files an appeal, the DA or SSA will review and reconsider the decision that resulted in an appeal. The final decision resulting from a DA/SSA internal reconsideration or review is also considered a decision subject to appeal.

A beneficiary or their representative also may ask that a decision be reconsidered even though no appeal has been filed. If so, the same procedures apply. Reconsideration by the DA or SSA is also optional in these cases.

Reconsideration Procedures

DAs and SSAs must establish and maintain their own internal procedures to review or reconsider service decisions. These procedures shall be established under standards established by DMH.

Reconsideration requests

All requests for reconsideration should be directed to the DA or SSA Grievance and Appeals Coordinator.

Timeframes

Any internal DA/SSA appeal process is part of the 45 day time frame for resolving appeals. A decision on reconsideration will be made within 15 days of receipt of the request or 15 days from the date the appeal was filed.

Reconsideration Decisions and Notices

DAs/SSAs will provide beneficiaries notice of the results of their internal review. If this results in a new decision, beneficiaries have 90 days to appeal that decision.

a. If the review affirms the original decision and the beneficiary accepts the decision, the appeal will be considered withdrawn. The DA will acknowledge the withdrawal within 5 days.

b. If the review affirms the original decision and the beneficiary is dissatisfied with the decision and requests further review, it will be resolved by the DMH appeal process within the 45 day timeframe for internal appeals.

c. If the beneficiary is uncertain as to whether or not they will accept the decision of the DA/SSA, they may request an extension of 14 days about whether they wish to pursue or withdraw the appeal. If the beneficiary fails to inform the DA/SSA of their preference within the 14 day extension, the appeal will be addressed by the MCO.

5. Expedited Appeals

Expedited appeals may be requested in emergent situations in which the beneficiary or the treating provider (in making the request on the beneficiary's behalf or supporting the beneficiary's request) indicates that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. Requests for expedited appeals may be made orally or in writing with the DA, SSA, or DMH for any actions subject to appeal. DMH will decide all expedited appeal requests, with the participation and advice of the DA/SSA.

The DA or SSA will not take any punitive action against a provider who requests an expedited resolution or supports a beneficiary's appeal. The expectations for DA or SSA staff support for documenting requests for expedited appeals will be consistent with the standard appeal process.

If the request for expedited appeal process does not meet criteria and is denied, the DMH will promptly inform the beneficiary that the request does not meet criteria for expedited resolution and that the appeal will be processed in the standard (45 days) time frame to resolve the appeal. An oral notice of the denial for an expedited appeal will be promptly communicated to the beneficiary and followed up within two calendar days with a written notice.

The written notice for any expedited appeal determination will include a brief summary of the appeal, the resolution and the basis for the resolution, and the beneficiary’s right to request a Fair Hearing subsequent to a final decision by the DMH

6. Filed appeals and logs

If an appeal is filed with the DA or SSA, it should be logged on to the MCO Grievance and Appeal electronic database on the day received, whether it was filed orally or in writing. The DA or SSA Grievance and Appeal Coordinator is responsible for logging all appeals into the MCO Grievance and Appeal electronic database

An acknowledgment of the appeal must be mailed by the DA or SSA to the beneficiary and beneficiary representative (if applicable) within five calendar days of receipt of the appeal. A copy should be sent to the DMH Administrative Support Coordinator.

7. Specific Procedures

a). Hospital Admission of CRT beneficiaries

The Vermont State Hospital (802-241-1000) should be contacted during evenings, weekends and holiday if the expedited appeal request involves the pending hospitalization of a participant in the Department of Mental Health Community Rehabilitation and Treatment (CRT) program.

b). Vermont's Act 264 procedures – LITs and SIT

Service recommendations concerning a youth's Coordinated Service Plan resulting from a Local Interagency Teams (LIT) or State Interagency Team (SIT) process are not MCO decisions subject to appeal.

However, if a contracted department of the MCO declines to provide or pay for a Medicaid funded service included in the recommendations of the LIT or SIT, the beneficiary may appeal that decision. The appeal should be directed to the specific department or agency that has denied, limited or declined to pay for the Medicaid service.

8. Administrative Support and Coordination

The appeal contact person for DAs and SSAs in the DMH is the DMH Administrative Support Coordinator. The DMH Grievance and Appeals Coordinator with the assistance of the DMH Administrative Support Coordinator will be responsible for managing the appeal process at the DMH level. The DAs and SSAs may contact them for questions and information. The designated DMH Appeal or Support Coordinator may be reached by calling (802) 652-2000.

Note: OVHA and DMH will maintain updated information on DMH and DA/SSA grievance and appeal contacts.

B. DA OR SSA GRIEVANCE PROCEDURES

1. Definition

“Grievance” means an expression of dissatisfaction about any matter that is not an “action” that can be appealed. Grievances include such concerns as the quality of care or services provided or aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect a beneficiary’s rights.

Any grievances related to a DA or SSA must be addressed by the DA or SSA. DMH will respond to all other grievances related to DMH programs or services.

2. Beneficiary complaints vs. grievances

All DAs and SSAs must have a clear grievance process for beneficiaries consistent with these procedures. To be a grievance there must include a clear statement by the beneficiary that a written response is requested.

Complaints often emerge in the normal course of health services. Complaints might include dissatisfaction with a service provider or service, but the beneficiary does not feel compelled to move the dissatisfaction forward in the grievance process.

If a beneficiary contacts the DA or SSA to express a concern, it is considered a complaint unless the beneficiary indicates that a written response is requested from the DA or SSA. The DA/SSA is responsible for making this determination during the conversation with the caller

If a beneficiary is dissatisfied with the manner in which a complaint is addressed, the beneficiary can seek to seek a resolution through the formal grievance process within the 60 day time frame for filing grievances by requesting a written response. If a response is requested, the DA or SSA Grievance & Appeal Coordinator will log the grievance onto the MCO Grievance and Appeal electronic database.

3. Filing Grievances

A grievance may be expressed orally or in writing. A grievance must include a clear statement by the beneficiary that a written response is requested from the DA or SSA. A beneficiary or his or her designated representative must file any grievance within 60 days of the pertinent issue in order for the grievance to be considered. DA or SSA staff members will assist a beneficiary if the beneficiary or his or her representative requests such assistance.

4. Alleged Harm

If a grievance is composed of a clear report of alleged physical harm or potential harm, the MCO will immediately investigate or refer to the appropriate investigatory body (fraud, malpractice, professional regulation board, Adult Protective Services)

5. Administrative Responsibilities

The DA or SSA Grievance and Appeals Coordinator is responsible for all administrative functions related to grievances. The Grievance and Appeals Coordinator will ensure that grievances filed with the DA or SSA are addressed by the appropriate DA or SSA staff person as set out in DA or SSA policies.

DA or SSA responsibilities include the following functions:

- Acknowledging grievances
- Gathering information,

- Writing responses
- Mailing grievances responses
- Entering data into and managing the MCO Grievance and Appeal electronic database as it applies to the DA or SSA.

6. Written Acknowledgment

Written acknowledgment of the grievance must be mailed within five calendar days of receipt by the DA or SSA. If the DA or SSA decides the issue within the five day time frame, it need not send separate notices of acknowledgment and decision. The decision notice is sufficient in such cases.

The DA or SSA Grievance and Appeals Coordinator will have responsibility for acknowledging all grievances. Copies will be sent to the beneficiary and beneficiary representative if applicable.

7. Withdrawal of Grievances

Beneficiaries or designated representatives may withdraw grievances orally or in writing at any time. If a grievance is withdrawn orally, the withdrawal will be acknowledged by the DA or SSA Grievance and Appeals Coordinator in writing within five calendar days.

8. Written Response

All grievances shall be addressed by the DA or SSA within 90 calendar days of receipt. The decision maker must provide the beneficiary with a written response to the grievance. The written response shall include a brief summary of the grievance, information considered in making the decision, and the disposition. If the response is adverse to the beneficiary, the response must also inform the beneficiary of his or her right to initiate a grievance review with the DMH, as well as information on how to initiate such review. Although the disposition of a grievance is not subject to appeal to the Human Services Board, the beneficiary may request a Fair Hearing for any issue raised that is appropriate for review by the HSB as provided in 3 V.S.A Section 3091 (a).

Copies of the disposition will be sent to the beneficiary and beneficiary representative if applicable. A copy should also be sent to the DMH Director of Adult Mental Health or the DMH Director of Children's Mental Health as applicable.

9. Timely Response

If a grievance is not acted upon within the timeframes specified in rule (90 days), the beneficiary may file an appeal under the definition of an action that includes, "failure to act in a timely manner when required by state rule".

C. DMH GRIEVANCE REVIEW

1. Grievance review

If a grievance is addressed by a DA or SSA is in a manner adverse to the beneficiary, the beneficiary may request a review by DMH within 10 calendar days of the decision. The review will be conducted by an individual who was not involved in deciding the grievance under review and is not a subordinate of the individual who decided the original grievance.

The DMH Administrative Support Coordinator will have responsibility for acknowledging grievance review requests within five calendar days of receipt. The MCO quality goal is to complete all grievance reviews within 45 calendar days.

2. Grievance Review Disposition

The grievance review will assess the merits of the grievance issue(s), the process employed in reviewing the issue(s), and the information considered in making a final determination. The primary purpose of the review shall be to ensure that the grievance process has functioned in an impartial manner and that the response was consistent with the issues and/or facts presented. The beneficiary will be notified in writing of the findings of the grievance review, which is considered final.

SECTION II

DMH APPEAL AND GRIEVANCE PROCEDURES

A. DMH APPEALS

1. Applicability of procedures

These procedures apply to consideration of appeal of "actions" that are subject to appeal that have been made either by DMH or a DA or SSA. DAs and SSAs are responsible to reconsidering decisions made that are subject to appeal, for issuing notice letters, and for certain administrative functions in the appeal process DAs and SSAs are not responsible for hearing appeals. This responsibility rests with DMH.

2. Notices - original notice of a DMH decision

If the DMH makes a decision that meets the definition of an MCO action as set out below, the DMH Grievance & Appeals Coordinator has responsibility for issuing or ensuring that a Notice letter is issued to the beneficiary. An "action" that is subject to appeal includes an occurrence by DMH of one or more of the following:

a. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;

b. reduction, suspension or termination of a previously authorized covered service or a service plan;

c. denial, in whole or in part, of payment for a covered service;

d. failure to provide a clinically indicated, covered service (no Notice letter);

e. failure to act in a timely manner when required by state rule (no Notice letter); or

f. denial of a beneficiary's request to obtain covered services outside the network.

Note: "Network" means the providers who are enrolled in the Vermont Medicaid program and who provide services on an ongoing basis to beneficiaries.

2. Timeframes

Beneficiaries have 90 days from the date on the decision letter to request an appeal. An acknowledgment or decision (if made) will be mailed within five calendar days of receipt of the appeal. If a request for a Fair Hearing has not been made prior to a MCO appeal decision, the Fair Hearing request must be made within 30 days of the decision.

The DMH has 45 days to decide the appeal, with a possible 14-day extension with a possible 14-day extension requested either by beneficiary or OVHA for scheduling purposes or due the pending receipt of necessary medical information. The MCO's goal is to decide appeals within 30 days.

If a decision made by a DA or SSA is the subject of the appeal, the DA or SSA has 15 days within which to review and reconsider the decision. The 15 days is part of the 45 days available to decide an appeal but is an optional part of the process.

3. Acknowledgement

The DMH Administrative Support Coordinator is responsible for acknowledging appeals of decisions made by DMH. An acknowledgment or decision (if made) will be mailed within five calendar days of receipt of the appeal. Copies will be sent to the DA or SSA if applicable, the DMH Grievance and Appeals Coordinator and the beneficiary and beneficiary's representative if applicable.

4. Sending Notices

The DMH Grievance & Appeals Coordinator will have responsibility for issuing notices related to any DMH action requiring a notice to the beneficiary. Letters shall be in the format and with content approved by the Department and MCO (OVHA).

Notice letters concerning DA or SSA actions are sent by the DA or SSA.

5. DMH Reconsideration (optional).

A decision made by DMH may be reconsidered within 15 days of receipt of a request made by the beneficiary or beneficiary's provider or representative. The individual who made the original decision may reconsider the decision. If a new decision is reached, a new notice of decision must be issued.

6. Expedited Appeals

Expedited appeals may be requested in emergent situations in which the beneficiary or the treating provider (in making the request on the beneficiary's behalf or supporting the beneficiary's request) indicates that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. Requests for expedited appeals may be made orally or in writing with the DA, SSA, or DMH for any actions subject to appeal. The DMH not take any punitive action against a provider who requests an expedited resolution or supports a beneficiary's appeal.

The expectations for DMH staff support for documenting requests for expedited appeals will be consistent with the standard appeal process.

If the request for expedited appeal process does not meet criteria and is denied, the DMH will promptly inform the beneficiary that the request does not meet criteria for expedited resolution and that the appeal will be processed in the standard (45 days) time frame to resolve the appeal. An oral notice of the denial for an expedited appeal will be promptly communicated to the beneficiary and followed up within two calendar days with a written notice.

The written notice for any expedited appeal determination will include a brief summary of the appeal, the resolution and the basis for the resolution, and the beneficiary's right to request a Fair Hearing subsequent to a final decision by the DMH

7. Hearing Appeals

The DMH Director of Quality Management will have responsibility for hearing appeals. These appeals will be of "actions" either taken by a DA or SSA or DMH as applicable. The Director of Quality Management may appoint individuals with subject matter expertise to hear any appeal requiring additional expertise.

In all cases, appeals shall be decided by individual(s) from DMH who possesses the requisite clinical expertise to review such decisions. The individual who hears the appeal shall not have made the decision subject to appeal and shall not be a subordinate of the individual that made the original decision.

8. Beneficiary Participation in Appeals

The beneficiary, designated representative, or the beneficiary's treating provider, if requested by the beneficiary, has the right to participate in person, by phone or in writing in the meeting in which DMH is considering the final decision regarding their appeal. If the appeal involves a DA/SSA decision, a representative of the DA/SSA may also participate in the meeting. Beneficiaries, their designated representative, or treating provider may submit additional information that supplements or clarifies information that was previously submitted and is likely to materially affect the decision. They will also be provided the opportunity to examine the case file, including medical records and other documents or records, prior to the meeting.

The DMH Administrative Support Coordinator will have responsibility for scheduling and coordinating participation in any meeting involving beneficiary participation.

9. Special Procedures

a. Hospital Admission of CRT beneficiaries

> The Vermont State Hospital (802-241-1000) should be contacted during evenings, weekends and holiday if the expedited appeal request involves the pending hospitalization of a participant in the Department of Mental Health Community Rehabilitation and Treatment (CRT) program.

b. Vermont's Act 264 procedures – LITs and SIT

> Service recommendations concerning a youth's Coordinated Service Plan resulting from a Local Interagency Teams (LIT) or State Interagency Team (SIT) process are not MCO decisions subject to appeal.
>
> However, if a contracted department of the MCO declines to provide or pay for a Medicaid funded service included in the recommendations of the LIT or SIT, the beneficiary may appeal that decision. The appeal should be directed to the specific department or agency that has denied, limited or declined to pay for the Medicaid service.

10. Administrative Support and Coordination

The appeal contact person for providers in the DMH is the DMH Administrative Support Coordinator. The DMH Grievance and Appeals Coordinator with the assistance of the DMH Administrative Support Coordinator will be responsible for managing the appeal process,

mailing decisions, gathering information, writing the decision, arranging for consumer participation in meetings if requested, and managing information on the MCO Grievance and Appeal electronic database.

The designated DMH Grievance and Appeal Coordinator and /or Support Coordinator may be reached by calling (802) 652-2000.

B. DMH GRIEVANCE PROCEDURES

1. Definition

"Grievance" means an expression of dissatisfaction about any matter that is not an "action" that can be appealed. Grievances include such concerns as the quality of care or services provided or aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect a beneficiary's rights.

Any grievances related to a DA or SSA must be addressed by the DA or SSA. DMH will respond to all other grievances related to DMH programs or services.

2. Beneficiary complaints vs. grievances

A grievance must include a clear statement by the beneficiary that a written response is requested.

Complaints often emerge in the normal course of health services. Complaints might include dissatisfaction with a service provider or service, but the beneficiary does not feel compelled to move the dissatisfaction forward in the grievance process.

If a beneficiary contacts DMH to express a concern, it is considered a complaint unless the beneficiary indicates that a written response is requested from DMH. The DMH staff person handling the call is responsible for making this determination during the conversation with the caller. If a beneficiary is dissatisfied with the manner in which a complaint is addressed, the beneficiary can file a grievance by asking for a written response. If a response is requested, the DMH Grievance & Appeal Coordinator will log the grievance onto the MCO Grievance and Appeal database.

3. Filing Grievances

A grievance may be expressed orally or in writing. A grievance must include a clear statement by the beneficiary that a written response is requested from DMH. A beneficiary or his or her designated representative must file any grievance within 60 days of the pertinent issue in order for the grievance to be considered. DMH staff members will assist a beneficiary if the beneficiary or his or her representative requests such assistance.

4. Alleged Harm

If a grievance is composed of a clear report of alleged physical harm or potential harm, the MCO will immediately investigate or refer to the appropriate investigatory body (fraud, malpractice, professional regulation board, Adult Protective Services)

5. Administrative Responsibilities

The DMH Grievance and Appeals Coordinator, with the assistance of the DMH Support Coordinator, is responsible for overseeing all administrative function related to grievances and for ensuring that grievances are addressed in a timely manner. Administrative responsibilities include the following:

- Acknowledging grievances
- Gathering information,
- Writing responses
- Mailing grievances responses
- Entering data into and managing the MCO Grievance and Appeal electronic log system as it applies to the DMH.

6. Written Acknowledgment

Written acknowledgment of the grievance must be mailed within five calendar days of receipt by the DMH. If DMH decides the issue within the five day time frame, it need not send separate notices of acknowledgment and decision. The decision notice is sufficient in such cases.

The DMH Support Coordinator will have responsibility for acknowledging all grievances. Copies will be sent to the beneficiary and the beneficiary's representative if applicable.

7. Withdrawal of Grievances

Beneficiaries or designated representatives may withdraw grievances orally or in writing at any time. If a grievance is withdrawn orally, the withdrawal will be acknowledged by the DMH Support Coordinator in writing within five calendar days.

8. Written Response

All grievances shall be addressed by the DMH within 90 calendar days of receipt. The decision maker must provide the beneficiary with a written response to the grievance. The written response shall include a brief summary of the grievance, information considered in making the decision, and the disposition. If the response is adverse to the beneficiary, the response must also inform the beneficiary of his or her right to initiate a grievance review with the DMH, as well as information on how to initiate such review. Although the disposition of a grievance is not subject to appeal to the Human Services Board, the beneficiary may request a fair hearing for any issue raised that is appropriate for review by the HSB as provided in 3 V.S.A Section 3091 (a).

Copies of the disposition will be sent to the beneficiary and beneficiary's representative if applicable. A copy should also be sent to the DMH Director of Adult Mental Health or the DMH Director of Children's Mental Health as applicable.

9. Timely Response

If a grievance is not acted upon within the timeframes specified in rule (90 days), the beneficiary may file an appeal under the definition of an action that includes, "failure to act in a timely manner when required by state rule".

C. DMH GRIEVANCE REVIEW

1. Grievance review

If a grievance is addressed by DMH in a manner adverse to the beneficiary, the beneficiary or their representative may request a review by DMH within 10 calendar days of the decision. The review will be conducted by an individual who was not involved in deciding the grievance under review and is not a subordinate of the individual who decided the original grievance.

The DMH Administrative Support Coordinator will have responsibility for acknowledging grievance review requests within five calendar days of receipt. The DMH Grievance and Appeal Coordinator will have responsibility for addressing or arranging for DMH staff to address grievance review requests. The MCO quality goal is to complete all grievance reviews within 45 calendar days.

2. Grievance Review Disposition

The grievance review will assess the merits of the grievance issue(s), the process employed in reviewing the issue(s), and the information considered in making a final determination. The primary purpose of the review shall be to ensure that the grievance process has functioned in an impartial manner and that the response was consistent with the issues and/or facts presented. The beneficiary will be notified in writing of the findings of the grievance review, which is considered final.

D. ADMINISTRATIVE SUPPORT AND COORDINATION

The appeal contact person in the DMH is the DMH Administrative Support Coordinator. The DMH Grievance and Appeals Coordinator with the assistance of the DMH Administrative Support Coordinator will be responsible for managing the appeal process, mailing decisions, gathering information, writing the decision, arranging for consumer participation in meetings if requested, and managing information on the MCO Grievance and Appeal electronic log system.

The designated DMH Grievance and Appeal Coordinator or Support Coordinator may be contacted by calling (802) 652-2000.